EDMUND G. BROWN JR.
Attorney General of California
ARTHUR D. TAGGART
Supervising Deputy Attorney General
BRIAN S. TURNER
Deputy Attorney General
State Bar No. 108991
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-0603
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CECILIA BELMONTE FLORENDO** 2941 River Road Modesto, California 95351 **Registered Nurse License No. 456462** Respondent.	Case No. 2011-231 **A C C U S A T I O N**

Louise R. Bailey, M.Ed., RN (Complainant) alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 31, 1990, the Board issued Registered Nurse License Number 456462 to Cecilia Belmonte Florendo ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2011, unless renewed.

///

///

JURISDICTION

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

5. Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. Code section 2762 states, in pertinent part:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

11. "Ativan," a brand of lorazepam, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(16).

12. "Dilaudid," a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(K).

13. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M).

14. "Vicodin" is a compound consisting of 5 mg. hydrocodone bitartrate also known as dihydrocodeinone, a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4), and 500 mg. acetaminophen per tablet.

BACKGROUND INFORMATION

15. On or about January 25, 2007, at 1200 hours, two of Respondent's co-workers, Martinez and Sidhu, discovered a black purse sitting on the nurse's station desk. Martinez and Sidhu opened the purse to try to find out who it belonged to. While Martinez and Sidhu were looking in the purse for identification, they found one tubex of Morphine, one tubex of Dilaudid, one carpujet of Ativan, one tablet of Vicodin, and syringes that fit carpujet injections. Martinez

and Sidhu took the purse to the Medical Oncology Supervisor, N. Mason ("Mason"). Later that afternoon, Sidhu received a telephone call from Respondent asking her if anyone had found a black purse. Sidhu told Respondent that no purse had been found. Respondent described the purse to Sidhu and asked Sidhu to call her if she found the purse. Sidhu reported the telephone call to Mason. Mason called Respondent back and told her that the Director of Medical Oncology, E. Adams, was in possession of the purse and that she needed to speak with her.

16. On or about January 29, 2007, Respondent went to E. Adams' office to retrieve her purse. Respondent was asked about the narcotic medications found in her purse. Respondent admitted to diverting the medications.

FIRST CAUSE FOR DISCIPLINE

(Falsified, Made Incorrect or Inconsistent Entries In Hospital or Patient Records)

17. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(e), in that while employed as a registered nurse at Emmanuel Medical Center, located in Turlock, California, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records in the following respects:

Patient 1:

a. On or about January 21, 2007, at 1937 hours, Respondent signed out one (1) 5 mg. tablet of Vicodin. Respondent charted the administration of one 5 mg. tablet of Vicodin at 2000 hours on the patient's Medication Administration Record ("MAR"), but failed to chart the administration of the Vicodin in the patient's nursing notes.

Patient 2:

b. On or about January 24, 2007, at 2205 hours, Respondent signed out one (1) 5 mg. tablet of Vicodin. However, Respondent charted the administration of two 5 mg. tablets of Vicodin at 2200 hours on the patient's MAR, when Respondent had only withdrew one tablet of Vicodin. In addition, Respondent charted the administration of two Vicodin tablets in the patient's nursing notes at 2315 hours, which is over one hour after withdrawing the Vicodin.

///

Patient 5:

c. On or about January 17, 2007, at 0240 hours, Respondent signed out one (1) 2 mg. injectable of Dilaudid. Respondent charted the administration of the Dilaudid on the patient's MAR at 0230 hours, but failed to chart the administration of the Dilaudid in the patient's nursing notes.

d. On or about January 21, 2007, at 2016 hours, Respondent signed out one (1) 2 mg. injectable of Dilaudid. Respondent charted the administration of the Dilaudid on the patient's MAR at 2015 hours, but failed to chart the administration of the Dilaudid in the patient's nursing notes.

e. On or about January 22, 2007, at 0238 hours, Respondent signed out one (1) 2 mg. injectable of Dilaudid. Respondent charted the administration of the Dilaudid on the patient's MAR at 0300 hours, but failed to chart the administration of the Dilaudid in the patient's nursing notes.

f. On or about January 22, 2007, at 2026 hours, Respondent signed out one (1) 4 mg. injectable of Dilaudid. Respondent charted the administration of the Dilaudid on the patient's MAR at 2015 hours, but failed to chart the administration of the Dilaudid in the patient's nursing notes.

g. On or about January 22, 2007, at 2203 hours, Respondent signed out one (1) 2 mg. injectable of Ativan. Respondent charted the administration of 1 mg. of Ativan on the patient's MAR at 2200 hours, but failed to account for the remaining 1 mg. of Ativan in any hospital or patient record.

Patient 6:

h. On or about January 21, 2007, at 2206 hours, Respondent signed out one (1) 4 mg. injectable of Morphine. Respondent charted the administration of the Morphine on the patient's MAR at 2200 hours, but failed to chart the administration of the Morphine in the patient's nursing notes.

i. On or about January 22, 2007, at 0247 hours, Respondent signed out one (1) 4 mg. injectable of Morphine. Respondent charted the administration of the Morphine on the patient's

MAR at 0330 hours, but failed to chart the administration of the Morphine in the patient's nursing notes.

j. On or about January 23, 2007, at 0002 hours, Respondent signed out one (1) 4 mg. injectable of Morphine. Respondent charted the administration of the Morphine on the patient's MAR at 0015 hours, but failed to chart the administration of the Morphine in the patient's nursing notes.

Patient 7:

k. On or about January 17, 2007, at 2031 hours, Respondent signed out two (2) 5 mg. tablets of Vicodin. Respondent charted the administration of the Vicodin on the patient's MAR at 2100 hours, but failed to chart the administration of the Vicodin in the patient's nursing notes.

l. On or about January 18, 2007, at 1935 hours, Respondent signed out two (2) 5 mg. tablets of Vicodin. Respondent charted the administration of one Vicodin on the patient's MAR at 2000 hours, but failed to account for the disposition of the remaining one tablet of Vicodin. In addition, Respondent failed to chart the administration of the Vicodin in the patient's nursing notes.

Patient 8:

m. On or about January 17, 2007, at 2304 hours, Respondent signed out one (1) 4 mg. injectable of Morphine. Respondent charted the administration of 2 mg. of Morphine on the patient's MAR at 2300 hours, but failed to account for the disposition of the remaining 2 mg. of Morphine in any hospital or patient record. In addition, Respondent failed to chart the administration of the Morphine in the patient's nursing notes.

n. On or about January 18, 2007, at 2056 hours, Respondent signed out one (1) 4 mg. injectable of Morphine. Respondent charted the administration of the Morphine on the patient's MAR at 2100 hours, but failed to chart the administration of the Morphine in the patient's nursing notes.

///

///

///

SECOND CAUSE FOR DISCIPLINE

(Obtained and Possessed Controlled Substances)

18. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(a), in that while employed as a registered nurse at Emmanuel Medical Center, located in Turlock, California, Respondent did the following:

a. On or about January 25, 2007, Respondent obtained Morphine, Dilaudid, Ativan, and Vicodin, all controlled substances, by fraud, deceit, misrepresentation or subterfuge or by the concealment of a material fact in violation of Health and Safety Code section 11173(a) when, while on duty, Respondent signed out the medications for the administration to various patients, but took them for her own personal use.

b. On or about January 25, 2007, Respondent possessed Morphine, Dilaudid, Ativan, and Vicodin, all controlled substances, in violation of Code section 4060, in that she did not have a prescription for those controlled substances.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent is subject to discipline under Code section 2761(a)(1), in that between January 17, 2010, and January 25, 2010, while employed as a registered nurse at Emanuel Medical Center, located in Turlock, California, Respondent committed acts constituting gross negligence, within the meaning of California Code of Regulations, title 16, section 1442, in the following respects:

a. Respondent obtained and possessed, Morphine, Dilaudid, Ativan, Vicodin, and syringes without a physician's order.

b. Respondent failed to conduct the appropriate pain assessment, both pre and post medication administration, as set forth in California Code of Regulations, title 16, sections 1443.5(1) and 1443.5(5), for patient 1, referenced above in paragraph 17(a), and another patient to be identified as patient 3.

c. Respondent failed to conduct a pain assessment for patient 4, prior to withdrawing medication for administration, as set forth in California Code of Regulations, title 16, sections 1443.5(1) and 1443.5(5).

d. Respondent made grossly incorrect, inconsistent, or unintelligible entries in hospital or patient records pertaining to controlled substances for patients 2, and 5 through 8, set forth above in paragraph 17(b) through (n).

FOURTH CAUSE FOR DISCIPLINE

(Incompetence)

20. Respondent is subject to discipline under Code section 2761(a)(1), in that between January 17, 2010, and January 25, 2010, while employed as a registered nurse at Emanuel Medical Center, located in Turlock, California, Respondent demonstrated incompetence, within the meaning of California Code of Regulations, title 16, section 1443, as set forth above in paragraph 19.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 456462 to Cecilia Belmonte Florendo;

2. Ordering Cecilia Belmonte Florendo to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/15/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2010100493
10574847.doc